Name:_____ **Date of Birth:**_____

Diagnosis:_____

Allergies:_____

Medications:_____

Today's Date:_____ **Form Completed By:**_____

Please answer the following questions about your health and development so we can help with your needs.
(YOU always refers to the YOUNG PERSON)

Staff Only ***F/U***	**Staying Healthy** **Medical Home:**_____	**YES**	**SOME -TIMES**	**NO**
	1. Do you have a medical home (family doctor or clinic) that you go to when your are sick or need a check-up?			
	2. Do you have regular check-ups with your medical home provider?			
	3. Are your immunizations up-to-date?			
	4. Are you happy with your weight?			
	5. Do you exercise three times a week or more?			
	6. Do you brush your teeth at least daily?			
	7. Do you have a check-up with a dentist at least once a year?			
	8. Do you have a soft formed bowel movement on a regular basis? (usually every other day)			
	9. Do you regularly use a seat belt?			
	10. Do you perform monthly self-exams? (testicular or breast)			
	11. Do you know how to prevent pregnancy & contracting HIV/AIDS and sexually transmitted diseases?			
	12. Do you understand the dangers of smoking, drinking, and using drugs?			

Name:_____ ID #: _____

Staff Only *F/U*	**Managing Your Own Healthcare** **Drugstore:_____**	**YES**	**SOME -TIMES**	**NO**
	13. Can you explain how your health problem affects your daily life?			
	14. Do you feel that your identified needs are being met?			
	15. Do you know when, how much, and why you take medications? (prescription and over-the-counter, like Tylenol)			
	16. Are you responsible for taking your own medications?			
	17. Do you know the side effects of your medications?			
	18. Are you able to get the medications, supplies, and/or equipment you need?			
	19. Are you able to pay for your dental needs?			
	20. Do you know how to use your insurance or Medical Card?			
Staff Only *F/U*	**Adult Healthcare**	**YES**	**SOME -TIMES**	**NO**
	21. Do you have a plan for finding your adult health care providers?			
	22. Have you found your adult health care providers?			
	23. Have you transferred your records to your adult providers?			
	24. Have you had your first appointments with your adult providers?			
	25. Do you know what things you need from the Commission before you complete your last clinic visit? (such as prescriptions and supplies)			

Name:_____ ID #: _____

Staff Only ***F/U***	**Being Independent**	**YES**	**SOME -TIMES**	**NO**
	26. Are you independent in your personal care?			
	27. Do you know how to go grocery shopping? (plan what to buy, find things in the store, pay for groceries)			
	28. Are you satisfied with how you are able to get around?			
	29. Do you have a plan for where you are going to live when you leave your family home?			
Staff Only ***F/U***	**Emotional Health**	**YES**	**SOME -TIMES**	**NO**
	30. Can you describe things that you are good at?			
	31. Do you know someone that you can talk with when you feel sad, nervous, or things aren't going well?			
	32. Do you have friends that you spend time with at least once a week?			
	33. Do you spend time doing things with your family at least once a week?			
Staff Only ***F/U***	**School & Work** **School/Employer:_____ Grade:_____**	**YES**	**SOME -TIMES**	**NO**
	34. Do you go to school/work regularly?			
	35. Do you think that your school/work assignments are at the right level for you?			
	36. Are you doing well in school and/or at work?			
	37. Does your school/work give you the necessary time and space to take care of your health needs?			

Name:_____ ID #: _____

Staff Only ***F/U***	**School & Work**	**YES**	**SOME -TIMES**	**NO**
	38. Is your school/work helping to address your needs for independent living?			
	39. Are you receiving the appropriate training for your chosen career?			
	40. Have you talked with someone about special programs that can help you pay for job training and college?			
	41. Do you have a volunteer or paying job?			
Staff Only ***F/U***	**CRS Satisfaction**	**YES**	**SOME -TIMES**	**NO**
	42. Are you pleased with the care you receive at CRS?			

What would you like to see done differently:

Information You Would Like to Have:

- ❍ Assistance Programs
- ❍ Medicaid
- ❍ Social Security
- ❍ Transportation
- ❍ Counseling
- ❍ School
- ❍ Sexual Development
- ❍ Independent Living
- ❍ Careers
- ❍ Colleges
- ❍ Scholarships
- ❍ Vocational Rehabilitation

STAFF USE ONLY:_____

Reviewed By:

Initials	Signature	Date